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ABSTRACT

The development of standardized performance measurements, the widespread use of such measures in Medicaid, and the planned uses of such measures in the Child Health Insurance Program (CHIP) provide significant opportunities for child advocates to improve child health services. This issue brief describes the growth of managed care organizations, presents characteristics of performance measurement, and explores the conceptual framework underlying performance measurement in managed care. The brief describes the major approach to performance measurement currently in use. Also described is the widespread and growing use of performance measurement tools by state governments to assess quality in Medicaid and CHIP plans. Finally, the brief discusses how child advocates can use performance measurement information to help improve CHIP and Medicaid services for children. (KB)

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Health Plan Performance Measurement: What It Is, How It Impacts CHIP and Medicaid, and Why Child Advocates Should Care

by Margaret Schmid

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Introduction

Child advocates have long understood the importance of good data in improving conditions for children. Data on eligibility and enrollments in the Child Health Insurance Program (CHIP) and Medicaid have been high priority topics among child advocates for some time. Child advocates have long been interested in data on quality and service as well. Once children are enrolled in CHIP or Medicaid, do they receive immunizations? Well-child care? Are providers available without delay? Do health plans give parents accurate and comprehensible information?

The emergence of managed care as a major form of health care delivery in the publicly funded child health environment may result in valuable new sources of credible data on health plan quality and performance, and give child advocates important new tools in their advocacy work. The growth of managed care has been accompanied by the development of a new type of performance measurement. This type of measurement utilizes precise, standardized methods, includes rigorous specifications for data elements, and produces comparable results. Based on the concept that managed care organizations[1] can and should be held accountable for providing services to their enrolled members, this approach to performance measurement is used widely for managed care organizations (MCOs) providing services to employees and their families, and is mandated by the federal Health Care Financing Administration (HCFA) for use by all Medicare managed care plans. States are also adopting this approach to performance measurement for use with their contracted Medicaid managed care organizations, and for MCOs delivering services to CHIP enrollees.

The development of standardized performance measurement, its widespread use in Medicaid, and its planned uses in CHIP programs around the country provide significant opportunities for child advocates to improve child health services. Performance measurement can increase the accountability of MCOs providing health care services to children in CHIP and Medicaid programs. It can drive programs of quality improvement in both the delivery of health care services and in consumer service. There are unique opportunities for child advocates in the states to play critical roles in shaping how performance measurement in CHIP and Medicaid is structured, how it is used, and whether it leads to improved health care for children.

This Issue Brief explores the conceptual framework underlying performance measurement in managed care. It describes the major approaches to performance measurement currently in use. It describes the widespread and growing use of performance measurement tools by state governments to assess quality in Medicaid and CHIP plans. Finally, it discusses how child advocates can use performance measurement information to help improve CHIP and Medicaid services for children.

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Managed Care Increasing

According to HCFA's most current data, as of June 30, 1998, Medicaid enrollment in comprehensive managed health care organizations (MCOs) and Medicaid-only MCOs totaled 11.9 million of a total of 30.9 million Medicaid beneficiaries. Since children ages 0-20 totaled 53.5 percent of Medicaid enrollees as of federal fiscal year 1997, we can estimate that approximately 6.3 million children are enrolled in Medicaid MCOs. This number is expected to continue to increase, since enrollment in Medicaid managed care is continuing to grow.[2] According to available descriptions of state CHIP plan applications, approximately two-thirds of the states indicated in those applications that they intended to use the same service delivery system for CHIP and for Medicaid, in whole or in part.[3]

Along with this increased use of MCOs as the vehicle for delivering health care services to children in publicly funded health care programs has come the increasingly widespread use of MCO performance measurement tools. Use of these new performance measurement tools offers many opportunities to child advocates.

These performance measurement tools are standardized, use precise definitions, have been tested for reliability and validity, and have been tested in the field. As a result, these tools can be used to accurately and reliably compare MCO performance in the actual delivery of care across plans, between states, and even nationally. Using these standard "measuring sticks," MCO performance can be compared year to year. Quality improvement programs can be applied with new rigor, since the same precise, standardized performance measure can be used to measure the baseline MCO performance and the level of MCO performance after the quality improvement intervention has been developed and implemented. Performance measurement results can be - and sometimes are - widely used in reports to legislatures, state officials, and the public. They can be used to develop benchmarks. Because of their precise and standardized nature, they can also be used for report cards comparing plan results for use by consumers and others. All told, they offer child advocates important new opportunities to ensure that, after children are enrolled, they receive quality health care services.

Performance Measurement Characteristics

Performance measurement in health care is not unique to managed care. However, the rapid growth of managed care organizations and the shift away from fee-for-service (FFS) medicine created a new demand for accurate information on how managed care plans performed, and for measurement which produced results that could be compared across health plans, across geographic locations, and over time. In effect, the emerging dominance of MCOs both allowed and required the development of performance measurement techniques peculiar to managed care.[4]

In effect, the emerging dominance of MCOs both allowed and required the development of performance measurement techniques peculiar to managed care.[4]

Managed care performance measurement is premised on the concept that managed care plans can and should be held accountable for providing quality care to their enrolled members. The nature of managed care performance measurement was shaped by the distinctive characteristics of MCOs.

An MCO has a *discrete, identifiable set of enrolled members. It is responsible for providing a defined set of services and benefits to them.* The health plan automatically receives a prepaid set amount each month for each member enrolled - the "capitation" payment. Whether or not benefits or services have been provided to some or all enrolled members, and whether or not benefits and services are utilized at, below, or above the levels and/or costs projected by the health plan, the health plan is responsible for providing the defined services and benefits for all enrollees, and for living within its budget. If the MCO's expenses exceed its revenues, it takes a loss. In FFS medicine, on the other hand, each individual seeks out providers, the providers administer whatever care they deem necessary or desirable, the providers bill the insurance company, and the insurance company pays. (Over time co-pays and deductibles were introduced to try to restrain utilization, but the basic concept remained unchanged.)

Only individuals who present themselves receive services; providers have no responsibility for outreach. There is no health care "budget." Neither the provider nor the insurance company is accountable to the patient or the purchaser (typically a private sector employer or a public entity such as a state Medicaid agency).

Further, in managed care, *the contract between the managed care plan and the purchaser describes the services that the plan is obligated to provide.* Because the capitation payment is based on calculations concerning the cost of these services and the extent to which they will be utilized by the projected enrolled patient population, plans are not obligated to provide services beyond the contractually specified limit. In FFS, there is no contractual description of services. As noted above, there is no budget. If spending exceeds that projected in a year, the insurance company raises rates for the next.

Among the defined services provided by managed care plans are preventive or well-care benefits - immunizations, routine physicals, screenings, well-child care - typically provided at low or even no cost to the enrolled member. The world of FFS was a world of sick care, not health care. So-called "health care" insurance covered only care for treatment when the patient was sick or had a condition which needed diagnosis. Managed care pioneered in the pro-

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vision of such preventive and well-care benefits. Until recently, the typical FFS insurance plan did not provide reimbursement for such services as preventive screenings or routine physicals, and coverage of such preventive and well-care services in the FFS world is still incomplete.

In managed care, *the managed care organization contracts with a specified list of providers* - doctors, psychologists, pharmacists, RNs, physical therapists, and more - *and with a specified list of facilities* - hospitals, clinics, and others - *to provide services to the members enrolled in that managed care plan*. Those providers and facilities agree to provide services to the plan's enrolled members under terms and conditions specified in the contractual agreement with the plan. The fact that such a contract exists means that provider behavior can be influenced by the managed care plan through a variety of means, including provider education, utilization review conducted by the plan, comparison of performance with specified clinical standards or with the performance of specialist peers within the plan, and financial arrangements designed to encourage or discourage specified types of provider behavior. As a result, plans have the opportunity to affect provider behavior in a fashion which is lacking in fee-for-service medicine. MCO ability to influence providers is a key factor underlying the demand for MCO accountability.

Additionally, managed care incorporates the concept that *enrollment over a reasonable period of time - "continuous enrollment" - is required before a health plan can be held accountable for delivery of services to members*. This is especially germane for preventive and well-care services such as immunizations, screenings, and other well-care services that are provided to plan members who are, by definition, well. Health plans are expected to conduct member outreach and provider education, among other things, to ensure high levels of preventive and well-child care, such health plan activities require time to accomplish. Building on these characteristics, new types of health care performance measurement have developed and become established.

It's a Simple Concept

Managed care performance measurement can be readily expressed as a simple fraction A/B=C.

For example, one widely used performance measure, the HEDIS measure of childhood immunization status (see section on HEDIS below), is designed as follows:

A/B = C, where:

- A is the number of eligible persons (enrolled children who turned 2 during the reporting year) enrolled for the requisite length of time (a year prior to their 2nd birthday) who actually received the service or benefit in question (the clinically desired vaccinations administered in the approved time sequence);
- B is the total number of eligible persons enrolled for the requisite length of time, regardless of whether they received the service (or even saw a provider); and
- C is the resulting rate of two year olds with the appropriate immunizations.

Performance measures describe how an MCO performs in providing a benefit or service where there is a known and clinically "desired" level, such as childhood immunizations. They describe MCO performance in areas in which there is not enough information to set a target level but where wide variation from the norm is suspect, such as utilization of inpatient services. They also reveal how an MCO rates in the views of its enrolled members on such matters as access to providers, referrals to specialty care, or thoroughness of care.

HEDIS®

Performance measurement in managed care is dominated by the measurement set with the unlikely acronym of "HEDIS" (pronounced hee-dis, which stands for "Health [Plan] Employer Data Information Set").

Use of the HEDIS performance measurement set is common among employer-based MCOs and is required by HCFA of Medicare + Choice MCOs (managed care organizations available to Medicare beneficiaries in many areas). Performance measurement is required of Medicaid managed care plans by the Balanced Budget Act of 1997 (BBA), is written into HCFA's Quality Improvement System for Managed Care standards (QISMC), and is included in the BBA legislation passed by Congress authorizing the CHIP program.

While the BBA does not require that HEDIS be used in Medicaid managed care, the American Public Human Services Association's (APHSA) study of HEDIS use cited earlier found widespread use of HEDIS performance measures to assess quality in state Medicaid programs. Twenty-eight states used or were planning to use HEDIS measures to monitor Medicaid managed care plan performance as of July, 1998.[5] A number of other states either already use other performance measurement techniques, or are considering what approach to adopt. A review of the intended performance measures listed in state CHIP plans submitted by 47 states and the District of Columbia found that all but four states reported plans to use all or part of the HEDIS performance measurement set to monitor the performance of their state CHIP programs.[6]

The HEDIS performance measurement data set is the product of over a decade of efforts begun by a group of health plans and large employers that wanted to differentiate among the quality of care provided by MCOs. It was continued by the National Committee for Quality Assurance (NCQA).[7] HEDIS is the most widely known and broadly used approach to MCO performance measurement at present.

HEDIS measures are highly precise, standardized, and prescribed. They are tested for validity, reliability, and feasibility. In general, HEDIS measures are calculated on the basis of data in medical records or in MCO administrative data bases. Allowable medical service codes are specified.

The exact time periods during which services must have been administered are delineated. Acceptable methods of documentation are described. A specific methodology for selecting medical records (if they are used) is provided and must be followed to ensure that they are statistically representative.

An illustrative description of a HEDIS measure, that of Adolescent Immunization Status, is below. In HEDIS Volume 2, Technical Specifications, this description is followed by four and one-half pages of definitions and specifications.

Description:

The percentage of Medicaid and commercially enrolled adolescents whose 13th birthday was in the reporting year, who were continuously enrolled for 12 months immediately preceding their 13th [with no more than one break of no more than 45 days] and who were identified as having had a second dose of MMR or a seropositive test result for measles, mumps and/or rubella and either three hepatitis B or a seropositive test result for hepatitis B and one VZV, a seropositive test result for VZV or evidence of chicken pox by the member's 13th birthday.

This precision – a precision reinforced by the HEDIS Compliance Audit developed by NCQA and conceptually akin to a financial audit – means that collection of the appropriate data can be a challenge, especially for health plans that do not have sophisticated management information systems. It also means that HEDIS results, especially when audited as required by HCFA for Medicare+Choice MCOs and by private sector purchasers for many commercial MCOs, are precise measuring tools. They can be used to identify trends in plan performance over time, to compare performance across plans, states or regions, to compare plan or state results against regional or national benchmarks, and to set quality improvement goals against which progress can be precisely measured. NCQA continues to update and modify its HEDIS measurement set annually, and has measurement development field testing underway on many measures, in particular those dealing with health outcomes and follow-up after acute illness.

It is important to note that several states are pioneering in the application of HEDIS measures to their Primary Care Case Management (PCCM) programs in addition to their Medicaid-MCOs. Approximately four million Medicaid beneficiaries are enrolled in PCCM programs. While technically considered "managed care" in the Medicaid environment, PCCM programs do not have the tightly managed systems characteristic of MCOs. Massachusetts has collected HEDIS data for its PCCM program for several years. Colorado has also begun collecting HEDIS results for its PCCM program as well as for its Medicaid MCOs.

The strengths of HEDIS are also its limits. HEDIS depends on accurate data. Information has its price: gathering data and ensuring its accuracy adds costs, both for health plans and purchasers. Additionally, the methodology is unforgiving. If an immunization is administered a day late, it cannot be counted in the plan's immunization rate; if a parent says that an immunization has been received but cannot provide acceptable documentation, no immunization can be reported.

Because of the complexity and cost of collecting and reporting HEDIS data, there are also limits to the number of measures which MCOs can be expected to report. HEDIS does not fully map the core elements of the EPSDT requirements, although it does

Table 1: HEDIS Measures Used by 13+ State Medicaid Agencies

Childhood immunization status	24 states
Well-child visits in the first 15 months	24 states
Adolescent immunization status	14 states
Well-child visits in the 3rd, 4th, 5th, and 6th years of life	19 states
Prenatal care in the first trimester	22 states
Adolescent well-care visits	17 states
Incidence of low birth-weight babies	13 states
Discharge and average length of stay-maternity care	22 states
Children's access to primary care providers	16 states
C-section and vaginal birth after C-section	18 states
Availability of primary care providers	15 states
Births and average length of stay, newborns	18 states
Initiation of prenatal care	13 states

Table 2: HEDIS Measures Slated for Use in CHIP Plans

Well Child Care	42 states
Emergency Room Utilization	31 states
Adolescent Well Visits	4 states
Mental Health Services Utilization	35 states
Immunizations	46 states
Dental Care	34 of the 44 states offering dental benefits

directly report some important components. There is competition among various constituencies as to what measures should have priority in development and in reporting. HEDIS describes "what is the case" with great precision, but sheds no light on underlying causes or explanations of variation. Finally, HEDIS' precision and largely clinical orientation limits its audience.

HEDIS, Medicaid, and CHIP

HEDIS is widely used in the Medicaid environment. As noted, at least twenty-eight states require Medicaid MCOs to report HEDIS results. In some states, the requirements have been in place for some years. Many states use these data for public reports or report cards, based in whole or in part on the results. The APHSA is developing the first national database of HEDIS reports submitted by MCOs serving Medicaid beneficiaries.

Some measures are in especially widespread use. Table 1 (page 4) lists the HEDIS measures which at least thirteen state Medicaid agencies require their contracted Medicaid MCOs to collect and report, listing the measure and the number of states requiring it on the right.[9]

While performance measurement in CHIP is in its infancy, Congressional language establishing the state CHIP programs required that each state "assure the quality and appropriateness of care" in its CHIP program. It also mandated that each state plan application "describe how performance under the plan will be measured through objective, independently verifiable means and compared against performance goals in order to determine the state's performance." Review of state CHIP plan applications show that many states plan to use HEDIS to satisfy these requirements in whole or in part. The HRSA/AHCPR[9] analysis of states' planned use of HEDIS measures in CHIP plans found that HEDIS measures are included in large numbers of state CHIP proposals. Table 2 (page 4) lists the major types of HEDIS measures included in state CHIP plan proposals, with the number of states indicated on the right.

Consumer Assessment of Health Plans (CAHPS)

HEDIS established the pattern for MCO performance measurement. However, the original set of HEDIS measures paid little attention to the perceptions of enrolled MCO members themselves. The HEDIS measurement set focused on measures of services with clinically based desired levels of performance; measures of member access to services; and measures of the utilization of various inpatient and outpatient services, few of which had clinically based target levels of performance. There were several smaller categories, largely descriptive in nature. While a member satisfaction measure was included, it was designed for the MCO enrollees receiving services through employer-provided MCOs, and received relatively little attention.

As interest in MCO performance grew, there was an increasing demand for reliable, standardized and comparable information on consumer views of MCO functioning to complement the more clinically oriented HEDIS measures of health plan performance. In 1994, AHCPR sponsored the development of the Consumer Assessment of Health Plans (CAHPS) survey by a consortium of the Harvard Medical School, RAND, and the Research Triangle Institute[10]. As with HEDIS measures, the CAHPS survey was field tested and evaluated for validity and reliability. It is available for use free of charge.

The CAHPS survey can be used to assess consumer satisfaction with FFS health care programs as well as managed care plans. Included in CAHPS are versions for Medicaid recipients and Medicare beneficiaries as well as for persons enrolled in employer-based plans, for parents or guardians to assess services provided to children, and for individuals with chronic diseases or disabilities. CAHPS has a core set of questions applicable across populations and health care delivery systems, and supplemental items specific to selected topics.

CAHPS is gaining new users rapidly. As of early 1999, it was being used by twenty states, ten employer groups, by Medicare, and by the Federal Employees Health Benefits Program, among others. CAHPS has been incorporated in HEDIS in lieu of the previous NCQA member satisfaction measure mentioned above.

CAHPS survey items tell us what enrollees think about their health plans in a variety of specific areas. Data analysis follows the HEDIS-like formula of A/B=C, generating measures of favorable and unfavorable perceptions concerning health plan functions held by a scientifically chosen sample of MCO members. Because the data needed for analysis is collected via phone or mail survey from individuals rather than from MCO administrative records or provider medical records in accordance with rigid protocols, there are fewer data collection problems with CAHPS than with HEDIS performance measures. This means that health care delivery systems with less structure and accountability than MCOs can also utilize CAHPS. A growing number of states are using CAHPS to compare the perceptions of Medicaid beneficiaries enrolled in MCOs, PCCM, and the FFS program.

CAHPS has many strengths, but it has limitations as well. The size and representativeness of the sample of members surveyed is the key to the validity of responses. Great care in survey administration and data analysis are essential. Poorly drawn samples, samples too small for generalization, or carelessness in survey administration and analysis can render the results meaningless, while variation in methods of survey administration and analysis can make comparison of results impossible.

Many CAHPS items are designed so that they can yield a composite measurement of a cluster of issues as well as scores on discrete items. A series of three illustrative questions taken from the CAHPS Child Medicaid-Managed Care Questionnaire (mail version) is shown in Table 3 (page 6).

Table 3: Illustrative CAHPS Questions

With the choices your child's health plan gave you, how much of a problem, if any, was it to get a personal doctor or nurse for your child you are happy with?

❍ A big problem ❍ A small problem
❍ I didn't get a new personal doctor or nurse for my child.

Do you have one person you think of as your child's personal doctor or nurse? If you child has more than on personal doctor or nurse, choose the person you child seems most often.

❍ Yes ❍ No

In the last 6 months, when your child went to his or her personal doctor or nurse's office or clinic, how often did the doctor or nurse talk with you about how your child is feeling, growing, and behaving?

❍ Never ❍ Sometimes ❍ Usually ❍ Always
❍ My child doesn't have a personal doctor or nurse.

The Foundation for Accountability (FACCT)

By the mid-1990s, the example of HEDIS and the increasing demand for information concerning managed care performance spawned the development of the Foundation for Accountability (FACCT)[11]. NCQA grew out of purchaser desires to differentiate among plan quality and continues to reflect assumptions concerning the impact of purchaser decisions on the health care industry. FACCT rests on the concept that more informed and empowered consumers can help shape a health care system which is more responsive to individual consumers' needs and desires.

In keeping with its consumer orientation, FACCT has emphasized the organization of performance measurement data from existing measures into "frameworks" which are more readily accessible to consumers and others outside of the health care industry. FACCT's framework includes the five categories below, and has been adopted by NCQA for its own HEDIS reporting:

- "The Basics" - Do people get the basics of good care? (e.g., access to care, customer service)
- "Staying Healthy" - Are people helped to avoid illness and stay as healthy as possible? (immunizations, screenings, well-care, counseling and anticipatory guidance)
- "Getting Better" - Are people who are sick helped to recover as quickly and fully as possible? (early, accurate diagnosis, good treatment and follow-up)
- "Living With Illness" - Do people get help to live as well as possible with ongoing illness? (good treatment and monitoring, education and counseling, symptom reduction, patient quality of life)
- "Changing Needs" - Do people receive needed support and care when their health or functional abilities change? (end of life care, care for people with disabilities)

In addition, FACCT has developed measurement sets for adult asthma, alcohol misuse, breast cancer, diabetes, major depressive disorder, health status and health risks, some of which compliment HEDIS measures related to the same condition. Some of these FACCT measures are being utilized in the field. It is currently developing measures of child and adolescent health through the Child and Adolescent Health Measurement Initiative (CAHMI), which it has undertaken in conjunction with NCQA. The measures, which take the form of extensive survey instruments, are:

- Promoting Healthy Development of children 0-3, a survey of parents concerning advice, counsel, and assistance they have received from their MCO;
- Adolescent Preventive Care, 14-18, which is developing items to be added to an adolescent version of CAHPS; and
- Living with Illness, a survey of families in MCOs with children with chronic or special health care needs.

At present these measures are being field tested.

Table 4 displays an illustrative question from the FACCT Promoting Healthy Development field trial (page 7).

How child advocates can use performance measurement to improve child health

The development of standardized performance measurement, its already widespread use in Medicaid, and its broad planned use in CHIP programs provide significant opportunities for child advocates to improve child health services in two broad areas:

- increasing accountability of MCOs providing health care services to children in CHIP and Medicaid programs, and
- driving effective programs of quality improvement in both the delivery of health care services and in consumer service.

As noted, the underlying concept of performance measurement is a simple one. It has not yet been widely embraced among advocates, in part because NCQA continues to be oriented toward purchasers, while CAHPS and FACCT are oriented toward individual consumers. However, there are unique opportunities for child advocates in the states to play critical roles in shaping how performance measurement in CHIP and Medicaid is structured, how it is used, and whether it leads to improved health care for children.

Most state Medicaid and/or CHIP agencies (where they are separate) have advisory bodies concerned with quality oversight matters. In some instances the membership

Table 4: Sample Interview Question from FACCT Healthy Development Field Trial

In the last 12 months, did your doctor or other health provider talk with you about the following:	YES, and I understand completely.	YES, and I understand pretty well.	YES, but I am still unsure.	NO, we did not discuss this but I wish we had.	NO, we did not discuss this but my questions were answered through other resources.
a. Your child's growth and development					
b. The kinds of behavior you can expect to see in your child					
c. How to dress, bathe, and feed your child					
d. The importance of talking, reading to, and playing with your child					
e. Things you can do to help your child grow and learn					
f. How to make your house and car safe for your child					
g. Ways to prevent your child from injuries due to falling down					

is specified in statute or regulation, but in many instances memberships are designated by the agency or open to interested parties. These bodies have a variety of titles, and vary in formality. What they have in common, however, is that they advise on key elements of performance measurement programs such as:

- what type of performance measurement the state requires;
- how vigorously the state implements its requirements with the affected MCOs;
- whether there is an advisory group bringing the MCOs together with other stakeholders; and, perhaps most important of all,
- what uses are made of the resulting measures.

In each of these areas, there is a wide range of potential decisions which advocates can help shape. Some courses of action lead to best health care for kids. Others lead to ineffective quality oversight, or to an emphasis on issues affecting state-MCO relations with less attention to the impact on enrolled children. If informed child advocates are at the table articulating the child-centered alternatives, the chances of better results increase.

For example, while performance measurement is required in both Medicaid and CHIP, states have wide discretion in what measurements they implement. Some use "home-grown" methods which have not been field tested, which do not necessarily yield reliable or valid results, and which cannot be compared across plans or with results from other states. Knowledgeable advocates can make the case for the use of proven performance method tools - HEDIS, CAHPS, or (eventually) FACCT, as at least a portion of the state's performance measurement strategy. Further, this advisory body is a good venue for discussion of whether the state's PCCM and/or FFS programs should also be subject to performance measurement requirements in order to spread the accountability net.

Whether the state's program is effectively implemented depends in part, as with any program, on resource allocation and priorities. Having knowledgeable child advocates at the table to reiterate the importance of the performance measurement program can remind everyone of the need to make the effort a priority and to allocate resources accordingly.

Some states have found it very effective to establish an advisory group on performance measurement in which the affected MCOs and state agency staff discuss the program, exchange information, and solve problems. Child advocates can propose the creation of such a group, and explain that they should also be included at that table. Their presence will reinforce the importance of moving ahead if the MCOs balk (a not unlikely event, given the complexity of data collection and stakes for the MCOs), and will implicitly remind state staff of the need to keep focused on the results for kids.

Most important of all is the fact that such advisory groups typically have significant input into decisions concerning the uses to which the performance measurement results will be put. There is a wide variety of possibilities. One is reports to legislators, and/or to the broader public. Sometimes this is legislatively mandated. It is generally an excellent idea, but only after at least one year of "practice" by the MCOs. First year results are virtually certain to reflect errors in the performance measure collection process as much as actual performance, especially where HEDIS is involved. It would be a public disservice to initiate the public reporting program with flawed data. Since it is well known in the health care industry that first year data are typically flawed, it might also provoke an understandable MCO backlash. (This is not to say that first year data should not be reported to the state and discussed by the state and MCOs - perhaps even the broader oversight committee, if circumstances permit.)

In the second and subsequent years, data might be used to produce "report cards" comparing MCO performance with that of other MCOs in the state and perhaps the PCCM program and/or FFS programs as well. Such report cards could be used in outreach and education programs to parent groups. Further, a review of performance measurement results can identify those areas in which each MCO has particular opportunities for improvement. The review could be used to advocate a plan whereby the state would work with each MCO to identify a target level of improved performance in one or two key areas to be reached within the year or perhaps two. Remeasurement should occur, using the same performance measurement tool. MCOs with particularly high performance improvement results could be rewarded, those who consistently fail could ultimately be sanctioned.

Conclusion

To begin, investigate how your state measures Medicaid and CHIP MCOs. Identify the advisory and oversight bodies, and find out how you can be included. Call on NACA's health staff for assistance. Opportunities to make a positive difference for children's health care are waiting for advocates to take advantage of them.

Endnotes

1 The term "managed care" is used here to mean only pre-paid, capitated managed care organizations plans - referred to here at "MCOs" - at risk for the cost of a comprehensive benefit package. It does not include contracts with plans for limited benefits, like behavioral health, nor does it include Primary Care Case Management (PCCM) systems. Note that in the Medicaid environment, PCCM programs are also technically considered to be managed care plans, as PCCM programs assign individual beneficiaries to a primary care case "manager" who is responsible for overseeing that individual's health care and for authorizing services. In a PCCM program, however, many or most actual health care services are delivered through the fee-for-service (ffs) health care delivery system.

2 An American Public Human Services Association (APHSA) publication, "Monitoring the Performance of Managed Care Plans: State Utilization of HEDIS," (Washington Memo, January 1999, pp. 3-8) found that, as of July 1998, 43 states and the District of Columbia had a contract with at least one MCO to provide Medicaid services.

3 1998 State Children's State Health Program Annual Report, National Conference of State Legislatures and the National Governors Association; APHSA web site at http://medicaid.uphsa.org/chippage/htm.

4 Evaluation tools have been produced by other organizations. However, these evaluation tools do not have the precision, reliability, or standardization of HEDIS, CAHPS, and FACCT measures which will be discussed in this Issue Brief, and cannot be used for the same kinds of plan comparison, benchmarking, and quality improvement measurement. As a result, they are not discussed here.

5 HEDIS and the other managed care performance measurement tools which will be discussed in this Issue Brief can be applied to the Medicaid Primary Care Case Management (PCCM) program, which enrolls over 4 million members, as well as to MCOs. Measurements of consumer attitudes can be applied to some aspects of fee-for-service programs as well.

6 Dr. Wendy Wolf, senior policy fellow, Agency for Health Care Policy and Research (AHCPR)/Health Resources and Services Administration (HRSA), presentation to a FACCT Task Force meeting, Washington D.C., June 3, 1999.

7 HEDIS is a trademarked product of the National Committee for Quality Assurance (NCQA). NCQA is a not-for-profit company with a board of directors including providers, health plans, consumers, labor unions, and large employers. NCQA is at 2000 L St., N.W.,Washington D.C. 20036. Its web site is www.ncqa.org. The HEDIS technical specifications, updated annually, are available from NCQA in HEDIS Volume 2, which currently costs $245. NACA is working with NCQA to develop an affordable method for child advocates to access this technical material.

8 APHSA report, op. Cit.

9 HRSA, Health Resources Services Administration. AHCPR, Agency for Health Care Policy Research.

10 Visit the CAHPS web site at www.ahcpr.gov/qual/cahps/ for information, and to download the CAHPS instrument and instructions for administration. For additional information, contact Christine Crofton, 301-594-2003, or Charles Darby, 301-594-2050, at the Center for Quality Measurement and Improvement, AHCPR.

11 FACCT is a not-for-profit organization governed by a Board of Trustees including consumer organizations, corporate purchasers, government purchasers, and providers and health plans. Information about the Foundation for Accountability (FACCT) and its Child and Adolescent Health Measurement Initiative can be located at the FACCT web site, www.FACCT.org, or from FACCT at 520 SW Sixth Avenue, Suite 700, Portland OR 97204, 503-223-2228.

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